Finalized SEER SINQ's

April 2012

Question: 20120035

Status
Final

Question
Reportability--Pancreas: Are well differentiated pancreatic endocrine neoplasms (PanNETs) reportable? If so, what is the histology code?

Answer
Pancreatic (neuro)endocrine neoplasms (PanNETs) are reportable. Well differentiated is grade 1 and the code is 8240/3.

Last Updated
04/05/12

Question: 20120034

Status
Final

Question
Primary site--Brain and CNS: What is the correct site/subsite code? MRI states: left cerebellar venous angioma. According to the WHO Classification of brain/cns tumors, code 9122/0 does not appear under tumors of the cerebellum (C71.6)

Answer
Code the primary site to cerebellum as indicted in the medical record. WHO does not list all possible primary sites for each histology.

Last Updated
04/05/12

Question: 20120029

Status
Final

Question
Primary site/Lung: What is the correct topography code for a small cell carcinoma presenting as mediastinal masses?

Answer
Code to mainstem bronchus, C340, in this case. Primary small cell carcinoma in the thymus/mediastinum is rare. A bronchial lesion with extension into the mediastinum is much more likely. In a case like this, it is difficult to be sure exactly where the tumor arose; however, we recommend that you default to main bronchus when there is no information to the contrary.

Last Updated
04/05/12

Question: 20110152

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Is this one primary lymphoma or two, and how did you determine the answer? See discussion.

Discussion
Patient admitted 11/4/10 for biopsy of abdominal mass, thought to be a cyst but turns out to be lymphoma. Path final diagnosis: Abdominal lesions involved by large cell lymphoma most consistent with DLBCL. Comment: based on the immunophenotypic pattern as well as the FISH results, it is favored that this represents a DLBCL most likely arising from transformation of mantle cell lymphoma. Burkitt-like lymphoma is excluded. CT scans of chest, abdomen and pelvis show widespread adenopathy and metastatic lymphoma involving pleura, spleen, and subcutaneous tissues. On 11/29/10, patient has a bone marrow aspirate and clot section with flow cytometry and peripheral blood smear. Comment: in contrast to the patient's prior lymphoma, the tumor cells were negative for cd 5 and for cd10. In the clot section, there is a small follicle with a histologic appearance consistent with low grade follicular lymphoma. This would correlate with the prior immunohistochemical and FISH findings on the patient's large cell lymphoma and likely represents an underlying low grade process. In addition, there are occasional areas with infiltrates of large mononuclear cells that were felt to represent either immature myeloid cells or possible focal invovement by the patient's management even in the presence of involvement by low grade lymphoma. Therefore, paraffin immunoperoxidase studies were undertaken for cd3 and cd20. Stain highlights the small lymphoid aggregates previously noted, but does not highlight the larger cell population which is felt to be most consistent with areas of immature myeloid and monocytic precursors. cd3 stain highlights cells scattered throughout the marrow. In summary, this bone marrow shows involvement by a lymphoma compatible with a low grade follicular lymphoma. No evidence of the patient's large cell lymphoma is noted.

Answer
Abstract two primaries: 1. DLBCL, 2. Follicular lymphoma.

Rule M13 was applied. The multiple primaries calculator shows that these are separate primaries.

Last Updated 04/05/12

Question: 20100016

Status
Final

Question
Reportability/Primary site/Histology--Brain and CNS: Are intraosseous meningiomas and sphenoid wing meningiomas reportable as one or more primaries?

Discussion
Research states:

1) An intraosseous meningioma is one that grows within a bone. Presumably, in this location meningiomas originate from arachnoid cap cell rests (islands) found in or along vascular channels coursing through the skull (such as diploic or emissary veins or nutrient arteries). Frequently, the location for an intraosseous meningioma is in the sphenoorbital region (junction of the sphenoid bone's greater wing - "the temple" region - and the bone constituting the orbital cavity - "eye socket").

2) The sphenoid bone is a base-of-skull bone which has an inner half known as the medial sphenoid wing, and an outer flared part known as the lateral sphenoid wing. The medial sphenoid wing lies closely approximated to key cranial nerve and vascular ("neurovascular") structures including the optic nerve, internal carotid artery, cavernous sinus, cranial nerves 3-6, and so forth. The lateral sphenoid wing lies closely approximated to the frontal and temporal lobes and their separation known as the Sylvian or lateral fissure. A sphenoid wing WHO grade I meningioma therefore arises from arachnoid cap cells somewhere along the sphenoid wing, and is a benign tumor, although potentially troublesome depending on its size and its effect upon surrounding brain neurovascular structures.

Answer
Neither intraosseous nor sphenoid wing meningiomas are reportable at this time. These are rare meningiomas of the bone. Benign brain and CNS tumors must meet both site and histology criteria to be reportable. These tumors meet the histology criteria, but do not meet the site criteria -- bone is not a reportable site for benign brain and CNS tumors.

Last Updated
04/02/12

Question: 20081126

Status
Final

Question
MP/H Rules--Brain and CNS: Are stigmata of neurofibromatosis in the brain considered to represent reportable neurofibromatosis lesions? Please see discussion.

Discussion
Reference: SINQ 20051108; SINQ 20061018 Three year old patient with history of neurofibromatosis 1. 3/05 MRI of the brain showed right optic nerve glioma. It also showed heterogeneous high t2 signal in the middle cerebellar peduncles and near the genu of the internal capsules bilaterally are stigmata of neurofibromatosis type I. 3/08 MRI showed new mass suspicious for glioma in the hypothalamus. Clinical diagnosis is benign glioma secondary to diagnosis of neurofibromatosis. How many primaries are to be accessioned for this patient? Should the matrix principle be invoked for the second glioma? Should the behavior code for the glioma be 0?

Answer
For cases diagnosed 2007-2011:

Accession NF (9540/1) when there is CNS tumor -- a glioma or some other intracranial/intraspinal tumor. Stigmata of NF are reportable when the stigmata themselves are reportable tumors. For example, glioma, or another intracranial/intraspinal tumor. Do not report sitgmata that are only termed "stigmata seen on MRI," for example, without other reportable terminology.

Do NOT accession NF (9540/1) when there is only peripheral nerve/nervous system involvement.

Accession the neurofibromatosis itself only once per patient. Accession any initial neoplasm in the CNS separately. Abstract and code any subsequent CNS neoplasms according to the multiple primary brain rules.

Accession three primaries for the case described above. 1. Neurofibromatosis (C729 9540/1) 2. Optic nerve glioma (C723 9421/3)--> see below. 3. Hypothalamus glioma (C710 9380/0)

--> Optic nerve gliomas associated with NF are pilocytic astrocytomas. Code pilocytic astrocytoma as 9421/3 in North America.

Last Updated
04/05/12